

Social issues regarding the legal liability of specialists from the medical surgical system and the patient's rights

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Abstract

The debate that we aim to initiate in this mini-report is connected to the issue of legal liability of the surgeon for all the surgical and post-surgical consequences, in a context where the hospital (state or private) manager, has the legal obligation to ensure both a sterile space for carrying out surgeries, and subsequent medical attention in the medical units. In terms of public politics, Law no. 95 from 2006 brought about a new perspective over the medical act, the rights of patients and safety of the septic environment, in order to reduce to minimum potential nosocomial infections. Public health assistance represents the organized effort of the society for protecting and promoting the health of the population, this being possible by recourse to political and legal measures, programs and strategies addressed to the determinant factors in health condition, as well as by making sure that the institutions provide all the necessary services. Thus, the hereby study aims at approaching, in compliance with the legal provisions in the matter, namely, Law no. 95 from 2006 pertaining to the reform in the healthcare sphere, corroborated with Law no. 46 from 2003 pertaining to patient's rights and internal and international legal rules regarding medical ethics.

Keywords: surgery; social; liability; legal; patient's rights

Introduction

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Even more, the actual Code of Medical Deontology of the General Medical Council of Romania [1] is saying that in the medical activity performed in teams (hospital departments, residency type process of medical education), liability for medical acts belongs to the team coordinator, as part of his administrative and management duties, and to the physician who personally carries out the medical act, within the boundaries of his professional competence and the role he was assigned by the team coordinator. In the interdisciplinary teams, the team coordinator is considered to be the physician specialized in the field for which the major admission diagnosis was established, even if there are no special regulations stating otherwise. Also, full or partial entrustment of personal obligations to other persons, in the absence of personal control, represents deontological deviation, while expressing the informed agreement of the patient regarding the treatment, does not suppress the responsibility of the physician for potential professional errors (articles 11-13).

Also, currently, the doctrine regarding professional medical liability concludes that the relationship physician-patient tends to be a contractual and fiducial one, based on patient's freedom of choice in regards to his attending physician.

The *sine qua non* of the medical act is, legally speaking, a duty of care by which the physician assumes, by using his medical knowledge and deontology, to do whatever it is possible without guaranteeing a final result [1].

In what the liability of the medical act is concerned, the European legal framework established a legal system which works on the principle of risk control, reported to the technological and scientific stage, with the obvious reason of avoiding the increase of medical care expenses. The French opted for defining the therapeutic risk as the incertitude element, part of any medical act, due to either the unpredictable reactions of the patient or the inevitable circumstances – elements which exclude the technique or competence of the one carrying out the medical act. The Swedish, on the other side, run a regime of voluntary insurance, with no connection to the therapeutic risk, since it concerns complications caused by errors of negligence occurring during the diagnosis or the treatment. In order to establish whether this is about an error-diagnosis in the way of exerting the medical act or not, it is necessary to establish with objectivity if the level of knowledge allows the determination of an accurate diagnosis. Also, the prejudice associated to a septic complication is taken into consideration only if it is agreed that the patient was already bearer of the germ and the situations in which the risk was deliberately insured in order to avoid more severe consequences, shall not be covered. Legally speaking, such a regulation in the Swedish system is objectively connected to the patient's right of

choosing different medical procedures. In the contract of insurance, the Swedish system lays down a specific prejudice allowance procedure, and any disputing situation gets to be analyzed by a commission made up of Government assigned members, which studies the complaints. The system actually runs countervailing measures according to the category to which they fit, and as a result, the statistics show a dismissal of 50% of the allowance claims.

When referring to Germany, or more specifically, to the former German Federal Republic, amid the fact that patients used to set off criminal proceedings, the representatives of the order of physicians and insurers agreed on creating an independent committee, able to support patients in establishing facts [4,5], as well as in carrying out a potential medical expertise. When talking about a medical error, the Commission of reconciliation for situations in which liability cannot be clearly established, an official record of transaction with mutual concessions is being drawn-up. It is a functional system, which resulted in the reduction of civil suits on this matter. [6,7]

In Great Britain, we talk about a contractual civil liability, as a result of a diligence contract called "Legal duty to take care". There is a system of associations for the protection of physicians whose members benefit from assistance in situations of malpractice, in the sense of support in protecting the national interests of the guild, and of legal support, if the case, since the society has the duty to protect its members even if they were to die during such a procedure [8,9].

The American system determines the exam of free practice based on the existence of an insurance policy for malpractice. The Californian neurosurgeon David Spindle, creates the term *malpractice coverage*, in 1977, by simply affirming: "If you didn't have malpractice insurance, you simply couldn't practice there." [2,10].

When analyzing the multitude of public health systems, it is not difficult to notice a preoccupation for creating a balance between the actual medical act, the legal liability of the surgeon and an assumption of insurance on behalf of the hospital, under the umbrella of control and notices issued by the Ministry of Health, safety of the environment where the medical profession is carried out, as well as of the specific material resources needed.

In Romania, medical liability is closely related to carrying out the medical activity, correlated to principles underlaying the proper performance of the medical act. When analyzing these principles, it is easy to observe that a serious professional training, information and constant improvement of the physician, shall lead to the performance of a desirable medical process.

In terms of ethical rules, if we were to make an analogy between the medical field and other fields of activity, we shall notice that in the current medical system, ethical rules have an increased importance in comparison to ethical administrative, technical or legal rules. In this respect, among the regulation papers regarding the practice of the profession of physician, there can be named: The Statute of the General Medical Council, The Code of Deontology, Law pertaining to the practice of the profession of physician, foundation and operation of the General Medical Council of Romania, Law of Social and Health Insurance no. 154 from 23th July 1997, etc.

In Romania, according to the Code of Medical Deontology "The physician has absolute professional independence, absolute freedom of issuing medical prescriptions and medical papers that he considers necessary, within his competence boundaries, being completely responsible for his acts. In case of limitations by administrative and/or economic constraints, the physician is not responsible anymore." The responsibility that a physician has towards the papers that he carries out, can sometimes limit his actions, as a consequence of fear of attribution, by approaching less risky procedures, but less helpful, at the same time. Such cases bring about a desirable social behavior of the physician, who does not risk and does not fail, but he also does not have tangible results, which might have repercussions both for a current case and for further similar ones. Nevertheless, in the current medical field, there is an assessment system operating under the name of "risk-benefit report". Despite the fact that, according to art.34 from the Code of Medical Deontology, "patient's interest must come first", evaluating the risk-benefit report might be called into question due to the unassuming of a potential risk which would be attributable to the physician.

The risks of medical act belong to different categories of risks, and the physician must evaluate the smallest out of these, with a cautious attitude and knowledge, through a highly professional technique. Thus, there is a *desirable risk*, in the sense that it is calculated and controlled, situated against the undesirable and uncontrolled risk. Considered from a legal perspective, the risk might be subjected to norming, liable for an early evaluation, usually based on statistics and certain risks not subject to norming, which cannot be anticipated, since they are determined by totally unpredictable, emergent or of *force majeure* situations [2].

A correct risk evaluation by the surgeon implies a balanced analysis between professional freedom of choice and individual freedom of the patient, in order to avoid a disproportion between the accepted risk and unsuspected risk [3]. In this equation, we can notice that legally speaking, it intervenes, at last, the concept of *professional risk*, which implies taking all the safety measures, procedures reflecting a moral and professional deontology. The surgeon lives from the perspective of psychological

representation of medical decisions that he is forced to take, a gallery of feelings that must be juxtaposed with the oath of Hypocrites, entailing modesty, caution, diligence and tolerance.

Furthermore, an undoubtedly essential criterion is the consent of the patient concerning the risk taking in case of any surgical intervention, concise, correct and point-blank information of the patient, as the equivalent of free and clearly expressed agreement, which exonerates the physician of the responsibility of choosing the date of the actual medical act. From our point of view, the correct information of the patient about the intervention, namely, of the surgical intervention and its post-surgical consequences do not relieve him of the responsibility of the actual medical act. The medical solution suggested by the surgeon and assumed by the patient must reflect the objective analysis of the previous health condition of the patient, complications which might be caused by his medical history and condition prior to surgical intervention, carried out by the former.

In the field of medicine, the criminal liability of the surgeon is characterized by fault, a form of guilt which implies assuming the actual consequences of the medical act. From where we stand, we consider this a delicate legal matter, in the context of the physician assuming a *sine qua non* duty of diligence. For example, he cannot be accused if he thoroughly respected the procedure regarding the surgical intervention and the death of the patient did not reach the sphere of assumed and calculated risks, both by the patient and the physician, at the moment of the former's consent. Also, the surgeon is exonerated of any form of legal liability if the post-surgery death occurred due to technical conditions related to a good hospital management, which cannot be imputed to him. As concrete examples, we can talk about the non-insurance of the septic environment by using acquired medical substances through a procedure specific to public acquisitions, which does not comply with the quality parameters.

Other examples from practice, which transfer liability from the physician to the legal person, represented by the hospital where the actual medical act is carried out, are: the occurrence of some malfunctions in the equipment, non-compliance with the imposed norms, such as hygiene norms, non-compliance with the functional circuits, carrying out controls on departments and equipment verification, in order for it to run smooth.

Subsequent to the countless conflicts in regards to assuming responsibility by all the actors in the medical surgical system, there have been many proposals of system reformation, in the sense of shared competence, which ensures a balance between the rights of the patients, the responsibility of the surgeon and the hospital assuming responsibility for technical conditions and, implicitly, providing all the resources in order to carry out a high-quality medical act.

Within the current legal context, a procedure that does not entail the intervention of court authorities is represented by mediation, which facilitates the conciliation of any prejudice suffered by the patient and of any guilt, no matter how small, belonging to any responsible actor carrying out the actual medical act. This mediation procedure can be initiated on the basis of Law no. 192 from 2006 and implies the mutual agreement of the parties in going through this conciliation by cooperation and collaboration with an authorized mediator, resulting in a mediation agreement which clearly and unequivocally establishes the way of covering the prejudice produced to the patient and his waiver to any subsequent legal endeavor. It is absolutely true that this procedure can be used in the context of criminal liability of the surgeon or of the legal person represented by the hospital, and can represent a way of solving the civil aspect of the criminal trial, if the type of criminal act does not allow the exoneration of criminal liability by the mediation agreement, which implicitly represents a reconciliation between the parties.

The specialists in the field of medical liability have proposed a liability system of the appointed physician and the “flawless system.” Thus, in the medical system, there arises a complexity of the liability phenomenon and the theoreticians of the insurance system talk about creating an alternative through a “particular system of social safety”, by using different tools to determine whether the person has the right to receive the damage. Hence, it is suggested that some risks be covered by a “compensation in the absence of mistake.” After the medical staff makes its choice over some “compensations in the absence of mistake”, the patient shall be compensated for potential current and future damage and expenses, but they shall not substitute the pain and suffering. In the absence of a compensatory insurance for which the physician has not opted, the judicial proceedings shall be carried out based on the fault, according to the regular procedure of liability, in front of the Court. The flawless system is applied in Sweden and New Zealand, where there is no liability for the physicians and through the “flawless” system, damages for any kind of prejudice are paid, regardless the cause, covering all the medical expenses. Nevertheless, in these countries, the system of medical insurances is a very complex one, by which the government directly finances the available insurances for everyone.

As for the circumscription of the Romanian medical system, over time it has been intended an alignment in terms of legislation pertaining to medical care, with the international legislation, which finds itself at a level which might answer to the current trends of patients and physicians. The contractual relations between them shall be established according to the professionalism of the physician and his good reputation in the matter. Responsibility with no mistake is an aspiration for all the surgeons, taking into consideration the frequent

unforeseeable situations which might occur. In order to apply it, it only requires the implementation of a well-structured system, based on high-quality medical care, both post-surgery and prior to the actual medical act.

The states with public strategies for providing a high-quality medical act, implemented a system of fixing any potential prejudice caused by the health system in the light of insurances, working with a double meaning: both the malpractice insurance of the physician and the insurance policies contracted by the patient.

Conflict of Interest

Authors have no conflict of interest to disclose

Ethical issues

The study was approved by the Ethics Commission of the Dunarea de Jos University, Faculty of Medicine, Galati;

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